Provider Insider

Alabama Medicaid Bulletin **September 2001**

The checkwrite schedule is as follows: **09/07/01** **09/14/01**

As always, the release of direct deposits and checks depends on the availability of funds.

Medicaid Approves New EDS Account Manager

Keith Hollis has assumed the role as the new EDS Alabama Medicaid Account Manager effective June 25, 2001.

"I am looking forward to continuing my relationship with the Alabama Medicaid Agency and the providers of Alabama in my new role," Hollis said. "I am commited to providing excellent service for the medical community."

Mr. Hollis has been employed with EDS for 12 years. He served nine years on the Arkansas MMIS Systems team before accepting the position of Implementation Manager for Alabama's new MMIS account in 1998. After the implementation, he assumed the role of System Manager and then Deputy Account Manager for the Alabama account.

Former EDS Account Manager Ricky Pope accepted the EDS North Carolina Medicaid Account Manager position.

The Alabama Medicaid Agency would like to offically congratulate Keith on his promotion and would like to wish Ricky much success in his new position in North Carolina.

Apnea Monitor Coverage Has Been Revised

Before an Apnea Monitor is provided to a Medicaid recipient, it is a Medicaid requirement that the parent/caregiver has documentation showing that they have had CPR training and demonstrated proficiency in CPR and resuscitation methods. The staff providing CPR training must have a license/certification to provide such training.

Provider Notice 99-13, reflecting the amended Apnea Monitor policy was mailed to providers in August of 1999. The effective date of this provider notice was September 1, 1999.

The statement listed below is information used to support the revision to the Apnea Monitor coverage policy related to parents/caregivers having CPR training. This information was taken from an article entitled “Infantile Apnea and Home Monitoring.” This article was published in the National Institute of Health Consensus Development Conference Statement.

"All families who have babies with Apnea are encouraged to be trained in infant cardiopulmonary resuscitation (CPR) before the baby is discharged from the hospital. Although it is unlikely that you will ever have to use CPR, it is best that you be prepared."

It is the DME provider’s responsibility to ensure that parents provide them with documentation of CPR training. This documentation must show

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In This Issue...

Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Dept.*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other _____*

New HIPAA Compliant Transactions

The Health Insurance Portability and Accountability Act (HIPAA) administrative simplification provision directs the Secretary of Health and Human Services to adopt standards for administrative transactions, code sets, and identifiers, as well as standards for protecting the security and privacy of health data. An article in the previous *Provider Insider* entitled,"HIPAA and How It Will Affect the Provider Community," outlined many of the issues and changes being mandated for health care in our nation.

In an effort to ensure compliance with HIPAA transaction sets and begin the preparation for changes to the Alabama Medicaid system, EDS hosted teleconference sessions for the vendors and the technical staff of the provider community concerning EDS' remediation of the first phase of the HIPAA implementation. The purpose of these sessions were to provide information regarding the new HIPAA mandated **ANSI 835 Version 4010** (Electronic Explanation of Payment) transaction and the **NCPDP version 5.1** (Interactive Drug Claims) transaction set that will be implemented by Alabama Medicaid beginning **September 1, 2001**. Topics of interest included testing procedures, contact information, and element specific guidelines. These sessions were a success, reaching numerous vendors and answering important questions or concerns regarding the September 1, 2001 implementation.

EDS will continue accepting the current NCPDP 3.2.as well as the NCPDP 5.1 claims format transactions after September 1, 2001. EDS will provide the current 835 format and the HIPAA mandated ANSI 835 V4010 format formats to Providers after September 1, 2001. Our goal is to ensure all our vendors and providers can make this positive step toward HIPAA compliance. It is anticipated that most vendors and providers will be converted to this format by April 2002. Providers can refer their vendors to *http://www.medicaid.state.al.us/new/index.htm*. Vendors should register, allowing them to receive updates and specifications regarding HIPAA. Please continue to monitor the future issues of the *Provider Insider* for more information, as it becomes available.

REMINDER

Dental Providers

If you are experiencing any billing problems, please call the Medicaid Dental Program immediately at (334) 242-5997 or EDS Provider Assistance at (800) 688-7989

Improper Billing Noticed by Medicaid

Once again it has been brought to our attention that some providers are billing Medicaid recipients for services, such as a "hospital scheduling fee" and /or "hospital set-up or transfer fee." These providers are also receiving reimbursements from Medicaid for medically necessary services rendered during the same visit. This practice is in violation of Medicaid rules and should be discontinued immediately.

This issue was addressed in the January 1999 EDS Medicaid Provider Bulletin – "Rule 560-X-1-.07 (4) of the Alabama Medicaid Administrative Code states providers accepting payment must agree to do so for **ALL** medically necessary services rendered during a particular visit. Providers found in violation of this rule will be referred to Medicaid's Program Integrity Unit for investigation."

Medicaid is once again reminding **ALL** providers — federal regulation does not allow balance billing of recipients or splitting out covered procedures to decide which to bill to Medicaid versus the recipient. Recipients must NOT be billed for covered services. Providers identified in violation of the policy will be referred to the proper authorities.

Rule No. 560-X-6-.16.
Billing of Medicaid Recipients by Providers.

(1) A provider may bill Medicaid recipients for the co-pay amount, for Medicaid non-covered services and for services provided to a recipient who has exhausted his/her yearly limitations. Conditional collections to be refunded post payment by Medicaid and partial charges for balance of Medicaid allowed reimbursement are not permissible. Billing recipient for services not paid by Medicaid due to provider correctable errors on claims submission or untimely filing is not permissible.

Rule No. 560-X-1-.07

(3) Providers have freedom of choice to accept or deny Medicaid payment for medically necessary services rendered during a particular visit. This is true for new or established patients. However, the provider (or their staff) must advise each patient prior to services being rendered when Medicaid payment will not be accepted, and the patient will be responsible for the bill. The fact that Medicaid payment will not be accepted would be recorded in the patient's medical record, if one exists.

(4) Providers who agree to accept Medicaid payment must agree to do so for all medically necessary services rendered during a particular visit. For example, if pain management services are provided to Medicaid recipients during labor and delivery, e.g. epidurals, spinal anesthetic, these services are considered by Medicaid to be medically necessary when provided in accordance with accepted standards of medical care in the community. These services are covered by, and billable to Medicaid. Providers may not bill Medicaid recipients they have accepted as patients for covered labor and delivery related pain management services.

ICD-9 Diagnosis Codes Must List Highest Number

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3,4,or 5 digits). Medicaid has discovered that some diagnosis codes were erroneously loaded to our records. Medicaid will be deleting those codes in the near future. Please verify that the diagnosis codes you use are carried to the furthest subdivision.

Medicaid Requires Blood Lead Test for Children

Screening with a blood lead test is the only way to determine if a child is exposed to lead. Significant adverse health effects, including effects on children's ability to learn, are found even at blood lead levels as low as 10 micrograms per deciliter (ug/dL). Blood lead levels as low as 10 ug/dL can harm a young child's ability to learn by causing decreased IQ, shortened attention span, hyperactivity, and learning disabilities. Screening by risk questionnaire is not an adequate substitute for blood lead testing. The federal government requires screening, using a blood lead test, for all children enrolled in Medicaid at ages 12 and 24 months for several reasons. Some of the information on risk (from NHAMES survey, collected 1991-1994) include: 1) Children from poor families were eight times more likely to be poisoned than those from higher income families, 2) African-American children were five times more likely to be poisoned than white children, and 3) Eighty-three percent of children with severe lead poisoning (blood lead levels of 20 ug/dL or greater) were enrolled in Medicaid. Children between the ages of 36 and 72 months with no record of prior screening must also receive a screening blood lead test. A lead test may be performed at anytime deemed medically necessary. The American Academy of Pediatrics endorses this requirement. For more information, please refer to your Provider Manual, Appendix A, pages A-11 through A-12.

Americans With Disabilities Act Requirements

All providers of Medicaid services should be aware of the Provisions of Title III of the Americans with Disabilities Act which gives rights of equal access to places of public accommodation. Included in the definitions of public accommodations are pharmacies, professional offices of a health care provider, hospital, or other service establishment. The law provides that "a public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities." The Department of Justice does not permit a public accommodation to charge a person for the cost of the auxiliary aid provided. It has been reported to Medicaid that some health care providers may be charging Medicaid recipients for the cost for an interpreter or other auxiliary aid. Please be reminded that the law prohibits this. However, the cost for interpreters and other auxiliary aids may entitle a business to an income tax credit, as well as the usual business-related expense deduction. For more information, refer to the Association of the Deaf web site at *www.nad.org.* Further details are provided under the heading of "Legal Rights."

Medicaid Issues New Referral Form

There is a new referral form, Alabama Medicaid Agency Referral Form (form 362), that combines and replaces the:

- Lock-In Recipient Referral Form (form 192),
- EPSDT Referral Form (form 167),
- Patient 1st Referral Form (form 347), and
- Patient 1st/EPSDT Referral Form (form 345)

Effective July 1, 2001, form 362, Alabama Medicaid Agency Referral Form, should be utilized in lieu of the aforementioned referral forms and all referrals must be in writing. Written referrals should be received within 72 hours from the time the verbal authorization was given. Patient 1st providers (if applicable) should sign the referral form and maintain the original in his/her medical record. EPSDT providers (if applicable) should sign the referral form and maintain the original in his/her medical record. Copies are to be forwarded to consultants to be maintained in their medical records. Grace periods have been issued of six months (January 1, 2002) for form 347, and twelve months (July 1, 2002) for forms 167 and 345. However the effective date for use of the new form is July 1, 2001. To obtain the new referral form, please fax your request to Outreach and Education at (334) 353-5027.

REMINDER

Nursing Home Providers

As a reminder, nursing home claims cannot span calendar months. Each month must be billed on a separate claim. Claims spanning calendar months will be rejected with error code 3140, or denied with EOB code 314.

Important Information for Eye Care Providers

Medicaid has issued some important information concerning eye care providers. First, when billing for "add power", use procedure code V2199. Second, the Prior Authorization (PA) form is used for multiple requests such as private duty nursing, physical therapy, etc. The certification and recertification blocks are not intended for use by eye care providers but must be completed. Eye Care Providers should check "no" to both of these when completing the PA form. Also, remember to always put "02" (Eyeglasses) in the blank for "PA Type" which indicates the service for glasses, contact lenses, frames, etc. Lastly, do not complete any items regarding ambulance, i.e., "ambulance transport code, ambulance transport reason codes, or patient condition". The ambulance information is located to the right of the first and second diagnosis fields in Section 5 of the PA form. For more information, please refer to Chapter 4, Obtaining Prior Authorization, of your Provider Manual.

Dental Prior Authorization Update

Effective immediately, the following dental procedures will be taken off prior authorization. These procedures may be performed without submitting any request to Medicaid if a root canal treatment is in Medicaid claims history. This change will not be applied retroactively and services provided prior to July 15 must have received approval prior to provision.

D2750 – Crown - porcelain fused to high noble metal
D2751 – Crown - porcelain fused to predominantly base metal
D2752 – Crown - porcelain fused to noble metal
D2792 – Crown - full cast metal

This does not change our current policy stating that Medicaid covers crowns, post and core and buildups following completion of root canal therapy only. Crowns (excluding stainless steel crowns) are limited to the permanent anterior and posterior teeth following root canal therapy. Molars are limited to cast metal crowns only (Procedure code D2792).
Please note that the procedure codes below will still require prior authorization. The Agency is currently working to remove these from prior authorization and future updates will be forth coming.

D2950 – Core Buildup, including any pins
D2952 – Cast post and core in addition to crown
D2953 – Each additional cast post - same tooth (maximum of 2)
D2954 – Prefabricated post and core in addition to crown
D2957 – Each additional prefabricated post - same tooth (maximum of 2)

If your claim denies with EOB code 766 and you have documentation the recipient has a completed root canal that is not in Medicaid claims history, submit the x-ray, an original completed ADA claim form and a request for Administrative Review to: Dental Program, Alabama Medicaid Agency, 501 Dexter Ave, Post Office Box 5624, Montgomery, AL 36103-5624.

Hospitals and Ambulatory Surgical Centers should bill Inpatient/ Outpatient/ ASC Admission procedure code Z5158 without using a prior authorization number effective for date of service October 1, 2000 forward. Dental providers must continue to follow current policy and procedures for obtaining approval. Refer to Chapter 13 in your *Alabama Medicaid Provider Manual* for specific details regarding program requirements.

If you have any questions, please call the dental program at (334) 242-5997 or (334) 242-5472.

Medicaid's Health Assessment Course Exemptions

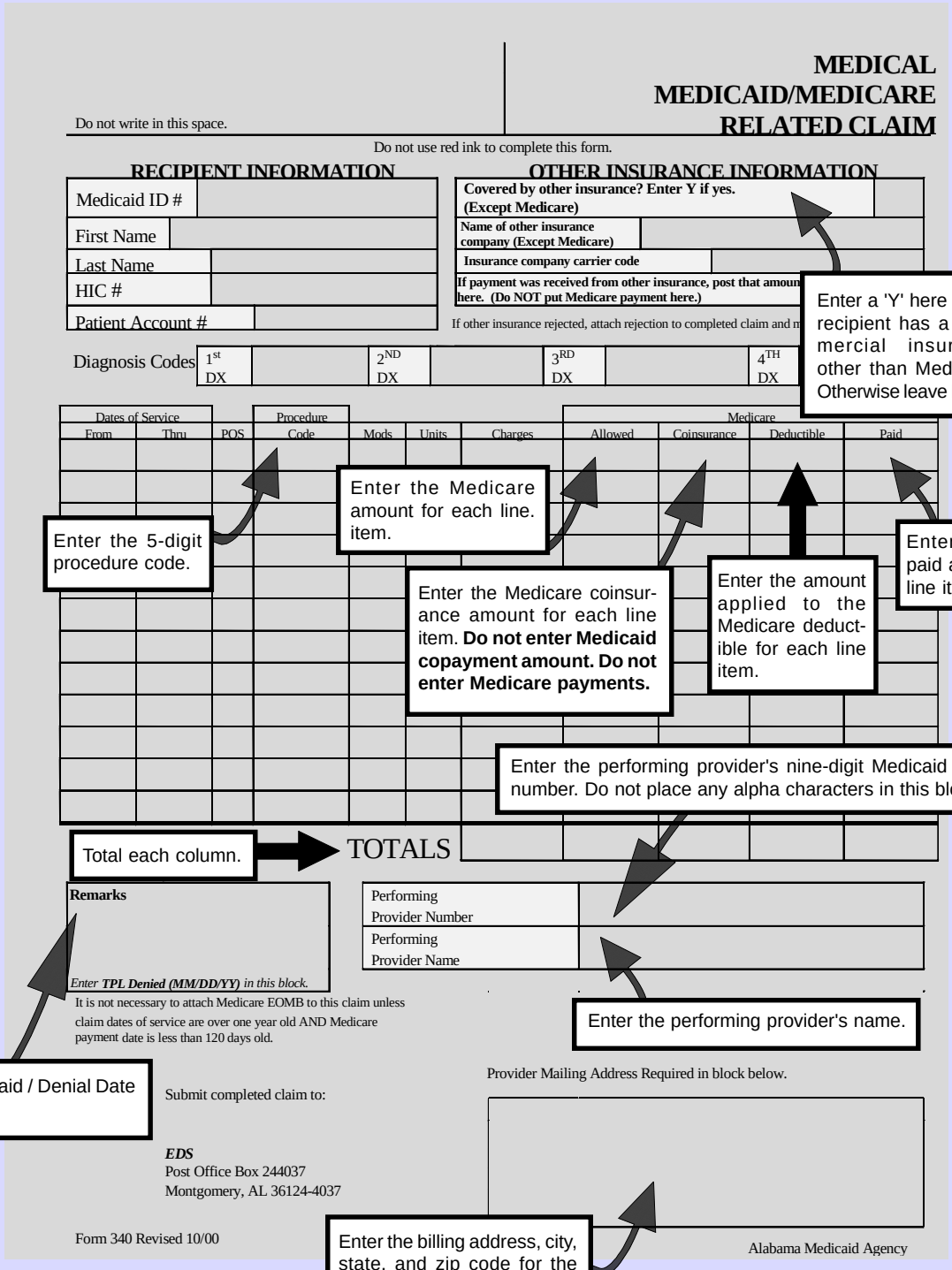
Registered Nurses and Well Child Check-Ups (EPSDT Screenings) RNs who have a bachelor's degree in nursing will be exempt from completing a Medicaid-approved pediatric health assessment course (PAC) in order to perform well child check-ups (EPSDT screenings). This became effective January 1, 2001. RNs without a bachelor's degree in nursing who wish to perform well child check-ups must first complete a Medicaid-approved PAC or show proof of completion of a similar program of study. Nurse practitioners and physician assistants are exempt from taking a PAC. For information related to places of service where RNs and mid-level practitioners may perform well child check-ups, please refer to your Provider Manual, Appendix A, section A.3.1.

Alabama Medicaid Guidelines for the Flu Vaccinations

Flu season is on its way! Flu vaccination (90657, 90658, 90659) is a covered service for Medicaid recipients regardless of age. Procedure codes 90657 and 90658 are covered through the Vaccines for Children (VFC) program and if you are not enrolled as a VFC provider, please refer recipients to your local County Health Department for flu vaccination. For more information regarding the VFC program, please refer to your Provider Manual, Appendix A, Section A.7.3. For procedure code 90659, the cost of administration of the vaccine may be billed using procedure code Z4998 if an office visit is not billed.

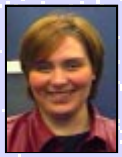
www.medicaid.state.al.us

Common Mistakes Providers Make on Medical Crossover Forms



EDS Provider Representatives

G R O U P 1



stephanie.westhoff
@alxix.slg.eds.com
334-215-4113

tasha.mastin
@alxix.slg.eds.com
334-215-4159

elaine.bruce
@alxix.slg.eds.com
334-215-4155

denise.shepherd
@alxix.slg.eds.com
334-215-4132

CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)
Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology

North: Tasha Mastin and Stephanie Westhoff

Bibb, Blount, Calhoun, Cherokee, Chilton, Clay, Cleburne, Colbert, Coosa, Cullman, DeKalb, Etowah, Fayette, Franklin, Greene, Hale, Jackson, Jefferson, Lamar, Lawrence, Lauderdale, Limestone, Madison, Marion, Marshall, Morgan, Pickens, Randolph, Shelby, St. Clair, Talladega, Tuscaloosa, Walker, Winston

South: Elaine Bruce and Denise Shepherd

Autauga, Baldwin, Barbour, Bullock, Butler, Chambers, Choctaw, Clarke, Coffee, Conecuh, Covington, Crenshaw, Dale, Dallas, Elmore, Escambia, Geneva, Henry, Houston, Lee, Lowndes, Macon, Marengo, Mobile, Monroe, Montgomery, Perry, Pike, Russell, Sumter, Tallapoosa, Washington, Wilcox

G R O U P 2

Mental Health/Mental Retardation
- MR/DD WaiverPublic Health
- Elderly and Disabled Waiver
- Home and Community Based Services
- EPSDT
- Family Planning
- Prenatal
- Preventive Education

Rehabilitation Services
- Home Bound Waiver

Therapy Services (OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics

Maternity Care
Hearing Services
Ambulance
FQHC

Nurse Midwives
Rural Health Clinic
Commission on Aging
DME

valerie.smith
@alxix.slg.eds.com
334-215-4142

mikki.summerlin
@alxix.slg.eds.com
334-215-4158

laquita.wright
@alxix.slg.eds.com
334-215-4199

G R O U P 3

ann.miller
@alxix.slg.eds.com
334-215-4156

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home
Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

Medicaid Will Provide Full Coverage For Breast and Cervical Cancer

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA) allows states to provide full Medicaid benefits to women:

- Who are screened and diagnosed through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are identified to be in need of treat ment for breast or cervical cancer, including pre-cancerous conditions of the breast or cervix and early stage cancer; and
- Who have no credible coverage for breast or cervical cancer; and
- Who are not otherwise eligible for Medicaid under another category; and
- Who are under age 65 or until the end of the month in which they turn 65;
- And meet Medicaid citizenship requirements.

The new legislation will allow those women who **have been screened and diagnosed with breast or cervical cancer through** the Alabama Breast and Cervical Cancer Early Detection Program **(ABCCEDP) providers** and who meet the requirements above, to receive treatment through the Alabama Medicaid Program.

Effective October 1, 2001, the Alabama Medicaid Agency will provide coverage for any woman who meets the eligibility requirements for Medicaid pursuant to this act. If eligible, she shall be entitled to medically necessary treatment for breast or cervical cancer and any other medically necessary Medicaid services covered under the Medicaid State Plan for the period of eligibility. Experimental treatments will not be covered. Eligibility ends when her course of treatment is completed or the state determines that she no longer meets eligibility criteria for this category.

As soon as an ABCCEDP provider diagnoses a recipient with breast or cervical cancer, the diagnosing provider needs to immediately contact Deborah Pennington at the Alabama Department of Public Health (ABCCEDP Program) at (334) 947-6206 to initiate the Medicaid application process. Ms Pennington's email address is *DeborahPennington@adph.state.al.us*.

The Alabama Medicaid Agency's guidelines for breast reconstruction surgery are outlined in Provider Notice 00-04, and the guidelines for breast prostheses are outlined in the July 2001 Provider Insider. If you need copies of these guidelines, please contact Medicaid's Outreach and Education Unit at (334) 353-5203.

Medicaid Now Covers Semi-Electric Extra Heavy Duty Hospital Beds

Effective August 1, 2001, Medicaid will begin coverage of Semi-Electric Extra Heavy Duty Hospital Beds to accommodate recipients who weigh more than 350 pounds, but less than or equal to 600 pounds. Medicaid will cover these semi-electric beds using Medicare's procedure code K0456 (Hospital bed, heavy duty, extra wide, semi-electric [head and foot adjustment] with any type rails, with mattress).

Medicaid will use the established prior authorization criteria for the hospital beds, but will add the weight, width and length requirements. Individuals approved for this bed must be fitted and measured by the Durable Medical Equipment Company providing these services.

Physician / Provider Reciprocal Arrangements

Claims must include the name and Medicaid provider number of the physician who takes responsibility for the services. The provider number must identify the responsible individual, not a group or institution. Reimbursement may be made to a billing physician submitting a claim for services furnished by another (performing) physician in the event there is a reciprocal arrangement as long as the claim identifies the physician who actually furnished the service. (The name of the physician who rendered services should be entered in block 19 of the HCFA 1500. Both physicians must be enrolled with the Alabama Medicaid Agency). The reciprocal arrangement may not exceed 14 continuous days in the case of an informal arrangement or 90 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Payment may not be made for services provided by providers who have been suspended or terminated from participation in the Medicaid program. For more information, please visit our website at *www.medicaid.state.al.us*, Alabama Medicaid Administrative Code, Chapter 6, Physicians.

Apnea Monitor Coverage

(Continued from Page 1)

proficiency in CPR and resuscitation methods. It is not the provider's responsibility to provide CPR training to the parents. However, the provider may direct the parents to agencies such as the Red Cross, Fire Departments, etc., where CPR training is provided. If a prior authorization request for an Apnea Monitor is submitted to Medicaid without this requested documentation, the request will be denied. The Prior Authorization Unit will request the provider to resubmit the prior authorization request with the needed documentation. No prior authorizations will be approved without this documentation.

State Fiscal Year 2001-2002 Checkwrite Schedule

10/05/01	01/04/02	04/05/02	07/05/02
10/19/01	01/18/02	04/19/02	07/19/02
11/02/01	02/08/02	05/03/02	08/02/02
11/16/01	02/22/02	05/17/02	08/16/02
12/07/01	03/08/02	06/07/02	09/06/02
12/14/01	03/22/02	06/21/02	09/13/02

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Montgomery, AL 36124-4035

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